

10587

CERTIFICATE OF DEATH

11841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Evadna Middle Sarrare Last Askins		4. DATE OF DEATH Month Oct. Day 29 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1956
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Chester		14. MOTHER'S MAIDEN NAME Ruth Askins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ruth Askins, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Influenza infection DUE TO 481X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Arterial Sclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/26 , 19 57 , to 3/26 , 19 57 , that I last saw the deceased alive on 3/26 , 19 57 , and that death occurred at 11 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Hanks M.D.		ADDRESS (Street, city or town, state) 104 Locust St Cambridge Md	
PHYSICIAN'S NAME (Type) W. H. Hanks M.D.		DATE SIGNED 10/3/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/2/1957	
22c. NAME OF CEMETERY OR CREMATORY East New Market		22d. LOCATION (City, town, or county) (State) East New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Hanks Jr		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR John Mace Jr.		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BATHINGORE 18

BUREAU V. S.

NOV 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10588
10605										
Items 11 & 12, Film G221, 10/10/57										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>					c. LENGTH OF STAY IN 1b. <u>1 yr. 4 mo.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>BRINSFIELD</u> Last <u>Edlon Park</u>					4. DATE OF DEATH Month <u>Oct.</u> Day <u>3</u> Year <u>19 57</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/13/80</u>		9. AGE (In years last birthday) <u>77</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Brookview, Dor. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Thomas H. Brinsfield</u>					14. MOTHER'S MAIDEN NAME <u>Harriet McAllister</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Eastern Shore State Hospital records</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis with cerebral arteriosclerosis</u>										
INTERVAL BETWEEN ONSET AND DEATH										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/22/56</u> , 19 <u>56</u> , to <u>10/3/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/3/57</u> , 19 <u>57</u> , and that death occurred at <u>11:35 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>E.S.S. Hospital, Cambridge, Md.</u> DATE SIGNED <u>Thomas J. Dredge, M.D.</u>										
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D.										
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlaw</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benard R. Thomas Camb. Md.</u>					24a. REC'D BY REGISTRAR <u>DATE 10/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Dredge</u>			

MEDICAL CERTIFICATION

RECEIVED

BUREAU V. S.

OCT 7 1957

10588

CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Benjamin Middle H. Last Brummell				4. DATE OF DEATH Month 10 Day 3 Year 1957			
5. SEX Male		6. COLOR OR RACE Col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-28-82	
9. AGE (In years last birthday) yrs. 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elick Brummell				14. MOTHER'S MAIDEN NAME Clara Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT John Copper, Trappe, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 yr. 3 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/30 , 19 57 , to 10/3 , 19 57 , that I lost the deceased alive on 10/3 , 19 57 , and that death occurred at 5:14 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 New St Cambridge, Md. DATE SIGNED							
ACTUAL SIGNATURE Lawrence Maryznov M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) Lawrence Maryznov				Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-7-57		22c. NAME OF CEMETERY OR CREMATORY Trappe Cem.		22d. LOCATION (City, town, or county) (State) Trappe Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR OCT 16 1957	
				24b. REGISTRAR'S SIGNATURE John Macey, Jr.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 16 1957

BUREAU V. E.

RECEIVED		OCT 16 1957		BUREAU V. E.	
STATE OF NEW YORK					
DEPARTMENT OF HEALTH					
OFFICE OF VITAL RECORDS					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED					
2. SEX					
3. AGE					
4. DATE OF BIRTH					
5. PLACE OF BIRTH					
6. OCCUPATION					
7. CAUSE OF DEATH					
8. PLACE OF DEATH					
9. TIME OF DEATH					
10. SIGNATURE OF DECEASED					
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10590

Reg. Dist. No.

10589

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 34 Edgewood Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lester Middle James Last Bryan				4. DATE OF DEATH Month Oct. Day 9 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1921	9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months 36 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Bryan				14. MOTHER'S MAIDEN NAME Minnie Corbin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-16-4360		17. INFORMANT Minnie Bryan, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cause unknown DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 0 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		DATE SIGNED 10/9/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/12/1957	22c. NAME OF CEMETERY OR CREMATORY Cordtown Cemetery		22d. LOCATION (City, town, or county) (State) Cordtown, Dor. Co., Md			
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. St. Lawrence		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR 10/10/57		24b. REGISTRAR'S SIGNATURE James M. [Signature]	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10590 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>25 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>21 Wells Street</u>				d. STREET ADDRESS <u>21 Wells Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Clark</u> Last <u>Clark</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH <u>Feb. 26, 1910</u>		9. AGE (In years last birthday) <u>47 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Thomas Clark</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Wollard</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>220-10-6925</u>				17. INFORMANT <u>Sarah Holland, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/25/57</u>			
EXAMINER'S NAME (Type) <u>JOHN MACE, JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem-Burial</u>		22b. DATE THEREOF <u>10/28/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Ceme.</u>			
22d. LOCATION (City, town, or county) <u>Washington, North Carolina</u>		24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert St. Lawrence</u>		ADDRESS <u>Cambridge, Md.</u>		DATE <u>10/25/57</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please give the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10320 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

RECEIVED
NOV 4 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G221 10-22-57 et

10592

10606

CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH o. COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Pennsylvania</i> COUNTY <i>Chester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>	c. LENGTH OF STAY IN 1b <i>5 months</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton Oxford</i> <i>75X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Shore State Hosp.</i>		d. STREET ADDRESS <i>1115 5th Street</i>	
3. NAME OF DECEASED (Type or print) <i>FLORENCE WEST CROTHERS</i>		4. DATE OF DEATH <i>October 11 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-19-78</i>
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. C.</i>	
13. FATHER'S NAME <i>James Polk West</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Bertha Thaysen</i> Address <i>Oxford, Pa.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO <i>Chronic Cardio-Vascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>General Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct. 11, 1957</i> to <i>Oct. 11, 1957</i> , that I last saw the deceased alive on <i>Oct. 11, 1957</i> , and that death occurred at <i>5:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ettore De Filippis</i> M.D.		ADDRESS (Street, city or town, state) <i>Eastern Shore State Hosp.</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>ETTORE DE FILIPPIS</i>		<i>Cambridge, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct 16 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Oxford Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Oxford, Chester Co Pa</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph McGeel</i> ADDRESS <i>Rising Sun, Md</i>		24a. REC'D BY REGISTRAR <i>15 1957</i>	24b. REGISTRAR'S SIGNATURE <i>John Mares</i>

OCT 4 - 1954

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10593

10591

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elliotts</u>	
c. LENGTH OF STAY IN 1b <u>1 week</u>		d. STREET ADDRESS <u>10460 cust</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LUCY ELLA Ewell</u>		4. DATE OF DEATH <u>10/16/1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/1879</u>
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Porter</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Porter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>10460 cust</u>	
17. INFORMANT <u>Mrs. Gordon Haller, Elliotts</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/5/1957</u> , to <u>10/16/1957</u> , that I last saw the deceased alive on <u>10/16/1957</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>10460 cust</u>		DATE SIGNED <u>10/19/57</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elliotts</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth S. McLaughlin, C. N. Market</u>		24a. REC'D BY REGISTRAR <u>John M. [Signature]</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>10/21/57</u>	

MAKYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. 1

1957-58-100

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10594

Reg. Dist. No.

10592

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN lb <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>410 Race St. Cambridge Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Preston</u> Middle <u>W.</u> Last <u>Harding</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/20/1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Business</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Collison W. Harding</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Harding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Preston W. Harding</u>				Address <u>410 Race St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic C. V. disease.</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Cambridge</u>		(State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 11/1/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>		DATE SIGNED <u>11/1/57</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
NOV 4 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10595

10607

CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>18yr. 5mo. 13da.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		d. STREET ADDRESS <u>22 x 2.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Horner</u> Last <u>Horner</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-79</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James L. Bedsford</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lloyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>RECORDS - E.S.S. Hospital, Cambridge, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anemia</u> DUE TO (c) <u>Cachexia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dementia Praecox, Paranoid Type</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-11-</u> , 19 <u>56</u> , to <u>10-30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-30</u> , 19 <u>57</u> , and that death occurred at <u>2:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin J. Ward</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10/30/57</u>	
PHYSICIAN'S NAME (Type) <u>Edwin J. Ward, M.D.</u>		M.D. <u>E.S.S.H., Cambridge, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/2/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Traskin Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Traskin, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. S. Measick, Briscoe, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 5 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>John Mace, Jr.</u>			

CERTIFICATE OF DEATH

1957

1. Name of deceased: [blank]
2. Sex: [blank]
3. Age: [blank]
4. Date of birth: [blank]
5. Place of birth: [blank]
6. Date of death: [blank]
7. Time of death: [blank]
8. Cause of death: [blank]
9. Place of death: [blank]
10. Signature of physician: [blank]
11. Signature of registrar: [blank]
12. Signature of informant: [blank]

BUREAU V. S.

NOV 5 1957

RECEIVED

10608

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Conchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Con</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market Md.</u>	
c. LENGTH OF STAY IN lb <u>4 weeks</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charay Newodale Jones</u>		4. DATE OF DEATH Month Day Year <u>Oct 22 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 24, 57</u>
9. AGE (In years last birthday) <u>4 wks.</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mom</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Frederick Jones</u>		14. MOTHER'S MAIDEN NAME <u>Inez Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Inez Jones</u>		Address <u>E. N. Market Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>772.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salmon Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Campen</u>		24a. REC'D BY REGISTRAR DATE <u>10/22/57</u>	
ADDRESS <u>East New Market Md.</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

4000247XV6

FOR STATE
HEALTH DEPT.

[Faint, mostly illegible text from the reverse side of the document, appearing as bleed-through.]

BUREAU V. S.

OCT 28 1957

RECEIVED

10593

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Leo</u> Last <u>Koski</u>		4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/11/1894</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Farm</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Farm</u>	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Koski</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Michalska</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Mr Frank Koski, Secretary</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic replints</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hangrene of rt foot</u> (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>6 mos</u> <u>13 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Ht. Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 4</u> , 1957, to <u>Oct 19</u> , 1957, that I last saw the deceased alive on <u>Oct 18</u> , 1957, and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Afred R. Maryanov</u> M.D. <u>136 Race St</u>		<u>10/22/57</u>	
PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV</u>		<u>Cambridge, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10/22/57</u>	<u>Our Lady's Immaculate</u>	<u>Secretary, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>John H. Bellamy</u>		DATE <u>10/23/57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
<u>John H. Bellamy</u>		<u>John H. Bellamy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 30 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10
CERTIFICATE OF DEATH

10-1-57

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
OFFICIAL USE ONLY: [illegible]

10609

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Madison				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Rural-Madison			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Francis Last Marine				4. DATE OF DEATH Month Oct Day 26 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 20, 1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmhand		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David R. Marine				14. MOTHER'S MAIDEN NAME Sarah Jane Keene			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-14-8523		17. INFORMANT Address John W. Marine, Church Creek, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis C.V.D. severe 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Artero-sclerotic gen. severe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emaciation							INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1 , 19 57 , to Oct 26 , 19 57 ; that I last saw the deceased alive on Oct 24 , 19 57 , and that death occurred at Cambridge, Md. from the causes and on the date stated above. ACTUAL SIGNATURE John W. Marine M.D. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED Oct 28, 1957 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/1957		22c. NAME OF CEMETERY OR CREMATORY Madison Cemetery		22d. LOCATION (City, town, or county) (State) Madison, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. Sallace Jr.				24a. REC'D BY REGISTRAR John W. Marine Jr.		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

10594

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge-Maryland Hospital</u>				d. STREET ADDRESS <u>RFD #3</u>			
3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>Matthews</u> Last <u>Matthews</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1897</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmhand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Matthews</u>				14. MOTHER'S MAIDEN NAME <u>Hager Matthews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Jefferson Matthews, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma Prostate</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 4, 1957</u> to <u>10/3, 1957</u> , that I last saw the deceased alive on <u>10/3, 1957</u> , and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Hanks</u>				ADDRESS (Street, city or town, state) <u>104 Locust</u>		DATE SIGNED <u>10/7/57</u>	
PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>				<u>CAMBRIDGE Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/7/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Clark</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10/14/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10384

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		BROWN		BLUE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
APR 4 1968		MEMPHIS		SHOOTING		SUICIDE		HEART DISEASE		BLOOD POISONING		NO		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		PLACE		CAUSE		MANNER		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
APR 4 1968		MEMPHIS		SHOOTING		SUICIDE		HEART DISEASE		BLOOD POISONING		NO		NO	

BUREAU V. 2

OCT 17 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10595 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>All life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>				d. STREET ADDRESS <u>11 Phillips St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Linda Laverne Meekins</u>				4. DATE OF DEATH Month Day Year <u>October 28 19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/9/52</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Clarence Elmer Meekins</u>				14. MOTHER'S MAIDEN NAME <u>Allien Curtis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital Records Cambridge, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia due to acute gastroenteritis.</u> <u>571.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert St. Clair</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>10/31/57</u>	
						24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

NOV 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10601

10610

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Eastern Shore State Hosp.</u> <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN <u>5 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hosp.</u>				d. STREET ADDRESS <u>05x0.2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM</u> <u>MELVIN</u>				4. DATE OF DEATH Month Day Year <u>October 5</u> <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-3-81</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Melvin</u>				14. MOTHER'S MAIDEN NAME <u>Esther Draper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Medical Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolus</u> <u>422.1</u> DUE TO <u>Amputation of left leg (mid-thigh)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic Cardiovascular Disease</u> DUE TO (c) <u>Chronic Cardiovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Oct. 5</u> , 19 <u>57</u> , to <u>Oct. 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 5</u> , 19 <u>57</u> , and that death occurred at <u>5:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ettore De Filippis</u>				ADDRESS (Street, city or town, state) <u>Eastern Shore State Hosp.</u>			
DATE SIGNED <u>Oct. 5, 1957</u>							
PHYSICIAN'S NAME (Type) <u>ETTORE DEFILIPPIS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 10, 1957</u>		<u>Mt. Olive</u>		<u>Sandtown, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Moore Sr.</u>				ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR DATE <u>10/9/57</u>	
						24b. REGISTRAR'S SIGNATURE <u>John Moore Jr.</u>	

RECEIVED

10596

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>In Ambulance</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>In Ambulance</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>Todd</u> Last <u>Meredith</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>19</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/12/1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Crocheron Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Todd</u>				14. MOTHER'S MAIDEN NAME <u>Malvinia Bramble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>James</u> Address <u>Mrs. Doris James 12 Washington St. Cambridge Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 yrs</u> <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Aug 6</u> , 19 <u>57</u> , to <u>Oct 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 19</u> , 19 <u>57</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> M.D.				ADDRESS (Street, city or town, state) <u>136 Race St Cambridge Md</u>			
PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV</u>				DATE SIGNED <u>10/21/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/22/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR <u>John Mace Jr.</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>10/22/57</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. S.

OCT 28 1957

RECEIVED

10597

CERTIFICATE OF DEATH

10603

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 25 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Race Street ext.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mayme Middle Parker Last Mills		4. DATE OF DEATH Month Oct.1,1957 Day 19 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov.22,1892
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Woolford, Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Clifton J. Parker		14. MOTHER'S MAIDEN NAME Daura Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Stewart O. Parker, Cambridge, Md. R.F.D.3	
17. INFORMANT Stewart O. Parker, Cambridge, Md. R.F.D.3		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alveolar cell carcinoma right lung with metastases 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 9 , 19 57 , to Oct 1 , 19 57 , that I last saw the deceased alive on Sept. 30 , 19 57 , and that death occurred at 7.10 A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) City Office Bldg. DATE SIGNED	
ACTUAL SIGNATURE Lewis M. Burdette M.D.		PHYSICIAN'S NAME (Type) Lewis M. Burdette Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct.3,1957	22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	22d. LOCATION (City, town, or county) (State) Cambridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR John Hall Jr. 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35 years	
4. RACE White		5. BIRTH DATE May 19, 1922		6. BIRTH PLACE Jackson, Tennessee	
7. MARRIAGE Single		8. OCCUPATION Minister of the Gospel		9. PRESENT ADDRESS Room 303, 535 North Dearborn Street, Chicago, Illinois	
10. DATE OF DEATH April 4, 1968		11. PLACE OF DEATH Memphis, Tennessee		12. CAUSE OF DEATH Gunshot wound of the chest	
13. MANNER OF DEATH Suicide		14. SIGNATURE OF DECEASED (Signature)		15. SIGNATURE OF PHYSICIAN (Signature)	
16. SIGNATURE OF WITNESS (Signature)		17. SIGNATURE OF MINISTER (Signature)		18. SIGNATURE OF CLERK (Signature)	

BUREAU V. 3

OCT 7 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10598

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10604

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 140 Pine Street			d. STREET ADDRESS 213 Pine Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Elwood Mitchell			4. DATE OF DEATH Month Day Year Oct 1, 1957		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1909	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Worcester Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME James Mitchell		
14. MOTHER'S MAIDEN NAME Viola Jones			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-22-7006			17. INFORMANT Beatrice Mitchell, Cambridge, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 mins.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. --- -- --		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --- -- --			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. -- -- 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- -- --	20f. (City or town) -- -- --	(County) -- -- --	(State) -- -- --
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Naturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Eldridge H. Wolff			DATE SIGNED 10-2-57		
EXAMINER'S NAME (Type) Eldridge H. Wolff, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/5/1957	22c. NAME OF CEMETERY OR CREMATORY Family Burial Ground	22d. LOCATION (City, town, or county) (State) East New Market, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Harper H. Sefton			24a. REC'D BY REGISTRAR DATE 10/16/57		
ADDRESS Cambridge, Md.			24b. REGISTRAR'S SIGNATURE John M. ...		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 14 1957
BUREAU V. 1

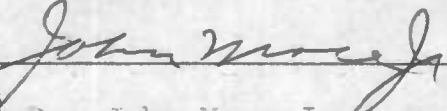
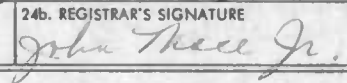
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10605

10599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.			c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Honga, Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital				d. STREET ADDRESS 1 Honga, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle B. Last Parker				4. DATE OF DEATH Month Oct. Day 29, Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1888		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Fishing		11. BIRTHPLACE (State or foreign country) Honga, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles M. Parker				14. MOTHER'S MAIDEN NAME Dora Creighton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT George W. Parker 2925 Sisson St. Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Petechial hemorrhages brain. 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was struck by car while walking on Rt. 335.					
20c. TIME OF INJURY Month, Day, Year Hour 5:30 o. m. 10/27 p. m. 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 335		20f. (City or town) (County) (State) Fishing Creek, Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/57		22c. NAME OF CEMETERY OR CREMATORY Hoosier Church		22d. LOCATION (City, town, or county) (State) Fishing Creek Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge Md.				24a. REC'D BY REGISTRAR DATE 10/31/57		24b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NOV 4 1957

RECEIVED

10611

CERTIFICATE OF DEATH

Reg. Dist. No. 64 116

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 27 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Minnie Middle Parrott Last Parrott		4. DATE OF DEATH Month Oct. Day 29 Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-81	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Wesley Downes		14. MOTHER'S MAIDEN NAME Sallie E. Downes (maiden name: Willey)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		
17. INFORMANT RECORDS - Eastern Shore State Hosp., Cambridge, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelitis DUE TO (c) Myocarditis, chronic				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis With Psychosis				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 10-2-1957 , to 10-29-1957 , that I last saw the deceased alive on 10-29-1957 , and that death occurred at 12:50 PM , from the causes and on the date stated above.				
ACTUAL SIGNATURE Edwin J. Ward		ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md.		
PHYSICIAN'S NAME (Type) Edwin J. Ward, M.D.		DATE SIGNED 10/29/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 1, 1957		
22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE J. Hampton Don		ADDRESS Federalsburg, Md.		
24a. REC'D BY REGISTRAR DATE 11-1-57		24b. REGISTRAR'S SIGNATURE Margaret A. Hampton John Mace, Jr.		

16

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10600

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b Few days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frances Middle Alverta Last Payton				4. DATE OF DEATH Month Oct. Day 22 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 30, 1903	
9. AGE (In years last birthday) 54 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Henry Stanley		14. MOTHER'S MAIDEN NAME Christina Pinder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Walter Stanley, Cambridge, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hemia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. Nephritis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 days ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/21 , 19 57 , to 10/25/57 , that I last saw the deceased alive on 10/22 , 19 57 , and that death occurred at 8:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Locust DATE SIGNED 10/25/57 ACTUAL SIGNATURE W. H. Hanks M.D. Cambridge Md. PHYSICIAN'S NAME (Type) W. H. Hanks							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/1957		22c. NAME OF CEMETERY OR CREMATORY Crossroads		22d. LOCATION (City, town, or county) (State) Dorchester Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. Sullivan ADDRESS Cambridge, Md.				24a. REC'D BY REGISTRAR John Mace Jr.		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

NOV 7 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10612

CERTIFICATE OF DEATH

10608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>one day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elisha</u> Middle <u>-</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night watchman</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Rink Phillips</u>	
14. MOTHER'S MAIDEN NAME <u>Sally Turner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>RECORDS: Eastern Shore State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular disease</u> DUE TO (c) <u>General Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-21</u> , 19 <u>57</u> , to <u>10-22-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-22</u> , 19 <u>57</u> , and that death occurred at <u>11:55</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ettore DeFilippis</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Ettore DeFilippis</u>		<u>Eastern Shore State Hospital, Cambridge, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10/25/57</u>	<u>Washington</u>	<u>Dorchester, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Whorby</u>		24. REC'D BY REGISTRAR <u>John M. Jones Jr.</u>	
ADDRESS <u>6. N. Nantux</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

PLACE OF DEATH A. HOME B. HOSPITAL C. NURSING HOME D. OTHER		MARRIAGE A. SINGLE B. MARRIED C. DIVORCED D. WIDOWED	
CITY OR TOWN OF DEATH A. BALTIMORE B. ANNE ARBOR C. BETHESDA D. BOWEN E. BRIGHTON F. BROOKLYN G. BUTLER H. CALVERT I. CARROLL J. CECIL K. CHESAPEAKE L. CLARK M. CLAY N. CLYDE O. COCKERMAN P. COLE Q. COMPTON R. CONNOR S. COOPER T. CROFT U. CUMMINGS V. CUNNINGHAM W. CUNNINGHAM X. CUNNINGHAM Y. CUNNINGHAM Z. CUNNINGHAM		COUNTY OF DEATH A. BALTIMORE B. ANNE ARBOR C. BETHESDA D. BOWEN E. BRIGHTON F. BROOKLYN G. BUTLER H. CALVERT I. CARROLL J. CECIL K. CHESAPEAKE L. CLARK M. CLAY N. CLYDE O. COCKERMAN P. COLE Q. COMPTON R. CONNOR S. COOPER T. CROFT U. CUMMINGS V. CUNNINGHAM W. CUNNINGHAM X. CUNNINGHAM Y. CUNNINGHAM Z. CUNNINGHAM	
DATE OF DEATH A. 1957 B. 1958 C. 1959 D. 1960 E. 1961 F. 1962 G. 1963 H. 1964 I. 1965 J. 1966 K. 1967 L. 1968 M. 1969 N. 1970 O. 1971 P. 1972 Q. 1973 R. 1974 S. 1975 T. 1976 U. 1977 V. 1978 W. 1979 X. 1980 Y. 1981 Z. 1982		TIME OF DEATH A. 12:00 AM B. 1:00 AM C. 2:00 AM D. 3:00 AM E. 4:00 AM F. 5:00 AM G. 6:00 AM H. 7:00 AM I. 8:00 AM J. 9:00 AM K. 10:00 AM L. 11:00 AM M. 12:00 PM N. 1:00 PM O. 2:00 PM P. 3:00 PM Q. 4:00 PM R. 5:00 PM S. 6:00 PM T. 7:00 PM U. 8:00 PM V. 9:00 PM W. 10:00 PM X. 11:00 PM Y. 12:00 AM Z. 1:00 AM	
CAUSE OF DEATH A. HEART DISEASE B. CANCER C. STROKE D. PNEUMONIA E. KIDNEY DISEASE F. LIVER DISEASE G. DIABETES H. HYPERTENSION I. COPD J. ALZHEIMER'S DISEASE K. PARKINSON'S DISEASE L. MULTIPLE SCLEROSIS M. EPILEPSY N. AIDS O. OTHER		MEDICAL HISTORY A. NONE B. CHRONIC C. ACUTE D. OTHER	
SIGNATURE OF DECEASED A. NONE B. CHRONIC C. ACUTE D. OTHER		SIGNATURE OF WITNESS A. NONE B. CHRONIC C. ACUTE D. OTHER	
SIGNATURE OF PHYSICIAN A. NONE B. CHRONIC C. ACUTE D. OTHER		SIGNATURE OF CORONER A. NONE B. CHRONIC C. ACUTE D. OTHER	

BUREAU V. 1

OCT 30 1957

RECEIVED
 DECEMBER 10 1957

10613

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 11yr.3mo.11das.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS -			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Walter Middle S. Last Porter				4. DATE OF DEATH Month October Day 20 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-23-76	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 23 Days 0 Hours 2		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George W. Porter				14. MOTHER'S MAIDEN NAME Tobitha Anne Blades			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unkn. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT RECORDS - Eastern Shore State Hospital Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver with metastasis to stomach and mesenteric glands 156.1 DUE TO (b) Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Ascites - Incontinence of intestine							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11-11 , 19 56 , to 10-20 , 19 57 , that I last saw the deceased alive on 10-20 , 19 57 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Edwin J. Ward				M.D. Eastern Shore St. Hospital, Cambridge, Md.			
PHYSICIAN'S NAME (Type) Dr. Edwin J. Ward				10-21-57			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Oct 25/57		22c. NAME OF CEMETERY OR CREMATORY Sharon Hill Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Thomas ADDRESS Sharon Hill Md.				24a. REC'D BY REGISTRAR OCT 24 1957 DATE		24b. REGISTRAR'S SIGNATURE Dr. J. Mace, Jr.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 24 1957

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MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

10610

10601

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Fishing Creek			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alma Middle Phillips Last Rhea				4. DATE OF DEATH Month Oct. Day 1 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/22/02		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Phillips				14. MOTHER'S MAIDEN NAME Mobalia Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 12 3909		17. INFORMANT William Ivy Rhea Address Fishing Creek, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 465x IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebothrombosis right femoral vein. DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 5 Min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John Mace Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10/2/57	
EXAMINER'S NAME (Type) John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/57		22c. NAME OF CEMETERY OR CREMATORY Hoosier Cemetery		22d. LOCATION (City, town, or county) (State) Fishing Creek Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge, Md.				24a. REC'D BY REGISTRAR DATE 10/2/57		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		HABIT		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		SIGNATURE OF EXAMINER		OFFICE		COUNTY		STATE																																	
JAMES M. WILSON		Male		45		1912		Maryland		White		Roman Catholic		Married		High School		Farmer		Sobriety		Heart Disease		Natural		Home		October 2, 1957		10:00 AM		J. M. Wilson		Baltimore		Baltimore		Maryland																																	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MARRIAGE		MOTHER'S MARRIAGE		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S HABIT		MOTHER'S HABIT		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S TIME OF DEATH		MOTHER'S TIME OF DEATH		FATHER'S SIGNATURE		MOTHER'S SIGNATURE		FATHER'S OFFICE		MOTHER'S OFFICE		FATHER'S COUNTY		MOTHER'S COUNTY		FATHER'S STATE		MOTHER'S STATE	
JAMES M. WILSON		JANE M. WILSON		Farmer		Homemaker		Maryland		Maryland		1912		1915		Roman Catholic		Roman Catholic		Married		Married		High School		High School		Farmer		Homemaker		Sobriety		Sobriety		Heart Disease		Heart Disease		Natural		Natural		Home		Home		October 2, 1957		October 2, 1957		10:00 AM		10:00 AM		J. M. Wilson		J. M. Wilson		Baltimore		Baltimore		Baltimore		Baltimore		Maryland		Maryland	

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 BUREAU V. 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10611

10602

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge.		c. LENGTH OF STAY IN 1b 4 months.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton, Maryland.		20.40.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 7 Brookletts Avenue.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emory Middle A. Last Ross.		4. DATE OF DEATH Month Oct. Day 25, Year 1957. 19	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Retired.	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Bernard W. Ross		14. MOTHER'S MAIDEN NAME Willie Jones.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Alice Leonard/		Address Easton, Maryla	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 430.1 (c) Instant		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		DATE SIGNED 10/28/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 28, 57	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill		22d. LOCATION (City, town, or county) (State) Easton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. Ellis Clark		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR 10/28/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

RECEIVED

OCT 30 1957

BUREAU V. S.

10614

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylors Island, Rural		c. LENGTH OF STAY IN 1b entire life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle R. Last Ruark		4. DATE OF DEATH Month Oct. Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83	IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min. 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer self-employed		10b. KIND OF BUSINESS OR INDUSTRY Taylors Island	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Ruark		14. MOTHER'S MAIDEN NAME Nancy Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Albanus Ruark, Cambridge, Md.		Address R.F.D. 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Senility			INTERVAL BETWEEN ONSET AND DEATH 2 wks ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma penis with metastasis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-20 19 56 , to 10/19 19 57 , that I last saw the deceased alive on 10/19 19 57 , and that death occurred at 5:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Locust St Cambridge Md DATE SIGNED 10/21/57			
ACTUAL SIGNATURE W. H. Hanks		M.D. 104 Locust St Cambridge Md	
PHYSICIAN'S NAME (Type) W. H. Hanks			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 21, 1957	22c. NAME OF CEMETERY OR CREMATORY Bethlehem Churchyard	22d. LOCATION (City, town, or county) (State) Taylors Island, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR John Mace Jr.		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b 30 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 38 Glasgow Street		d. STREET ADDRESS 38 Glasgow Street.	
3. NAME OF DECEASED (Type or print) First John Middle Summerfield Last Skinner		4. DATE OF DEATH Month October Day 28 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1972
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min. 84	IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min. 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired County Treasurer		10b. KIND OF BUSINESS OR INDUSTRY Cambridge R.F.D.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alexander Skinner		14. MOTHER'S MAIDEN NAME Sallie Lurty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Nellie P. Skinner, 38 Glasgow St., Cambridge, Md.	
17. INFORMANT Nellie P. Skinner, 38 Glasgow St., Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Hypertensive cardio vascular DUE TO (c) Arteriosclerosis, generalized and cerebral		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-5-46 , 19 to 10-28-57 , 19 that I last saw the deceased alive on 10-27-57 , 19 and that death occurred at 12.00 Noon M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Eldridge H. Wolff M.D. 15 Locust Street, Cambridge, Md.		10-29-57	
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 30, 1957	22c. NAME OF CEMETERY OR CREMATORY Old Trinity Churchyard	22d. LOCATION (City, town, or county) (State) Church Creek, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Berneth R. Howard		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR DATE 11/1/57		24b. REGISTRAR'S SIGNATURE John H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES EARL RAY		Male		35		Jan 5, 1928		Memphis, Tenn.		Actor	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
April 4, 1968		London, England		Gunshot wound to the chest		Suicide		[Signature]		[Signature]	
13. FULL NAME OF REGISTRAR		14. ADDRESS OF REGISTRAR		15. CITY AND STATE OF REGISTRAR		16. COUNTY OF REGISTRAR		17. ZIP CODE OF REGISTRAR		18. TELEPHONE OF REGISTRAR	
[Name]		[Address]		[City and State]		[County]		[ZIP Code]		[Telephone]	

BUREAU V. S.

NOV 4 1957

RECEIVED

10615

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalburg 05x2.2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Shore State Hosp.</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>GEORGE</i> Middle <i>SMITH</i> Last <i>JR.</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>6</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 7, 1883</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Block factory</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>same</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George Smith</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>22-1-15-5028</i>	
17. INFORMANT <i>Harvey Wilkin</i> Address <i>Federalburg, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> 422.1 DUE TO <i>Chronic Cardio-vascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Generalized Arteriosclerosis</i> (b) <i></i> (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>Oct. 5</i> , 19 <i>57</i> , to <i>Oct. 6</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Oct. 6</i> , 19 <i>57</i> , and that death occurred at <i>7:43 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ettore De Filippis</i> M.D.		ADDRESS (Street, city or town, state) <i>Eastern Shore State Hosp.</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>ETTORE DEFILIPPIS</i>		<i>Cambridge, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>10/8/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Oakwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Federalburg - rural</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey Wilkin</i> ADDRESS <i>Federalburg, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE 10/15/57</i>	24b. REGISTRAR'S SIGNATURE <i>John Mearns Jr.</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10615
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										10616
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cambridge</u>			c. LENGTH OF STAY IN 1b <u>8 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Rural Cambridge, Md.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge, Md. RFD # 3</u>					d. STREET ADDRESS <u>Cambridge, Md. RFD # 3</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Amelis</u> Last <u>Stewart</u>					4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>19 57</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/31/1900</u>		9. AGE (in years last birthday) <u>57</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edward O. Seward</u>					14. MOTHER'S MAIDEN NAME <u>Olive Davis</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. J. Alfred Stewart Cambridge Rt. 3</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>John Mace Jr.</u> EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10/25/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park Cambridge, Md.</u>			22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompt Funeral Service Cambridge, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>10/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>			

OCT 30 1957

RECEIVED

10617

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>				c. LENGTH OF STAY IN 1b <u>3 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>COLLINS</u> Last <u>TILGHMAN</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/20/63</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months <u>94</u> Days <u>22</u> Hours <u>16</u> Min. <u>2</u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>Ed J. Collins</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Lockwood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Eastern Shore State Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile Psychosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Psychosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct. 27</u> , 19 <u>54</u> , to <u>Oct. 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 21</u> , 19 <u>57</u> , and that death occurred at <u>10:45a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. <u>E.S.S. Hospital, Cambridge, Md. 10/21/57</u>							
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>							
22a. BURIAL, CREMATION, REMOVAL SPECIFY <u>Burial</u>		22b. DATE THEREOF <u>10/23/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co.</u>				ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>Dr. J. Mace Jr</u>	
				DATE <u>Oct 24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Norman Baker</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 24 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

10604

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>2 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland</u>				d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Martino Webster</u>				4. DATE OF DEATH Month Day Year <u>10 8 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/1/1874</u>	
				9. AGE (In years not birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Harrison Webster</u>				14. MOTHER'S MAIDEN NAME <u>Martha Langford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Raymond C. Webster - Secretary, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/29/57</u> to <u>10/8/57</u> , that I last saw the deceased alive on <u>10/7/57</u> , and that death occurred at <u>12:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter E. Gunby Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>105 CHURCH ST. CAMBRIDGE MD</u> DATE SIGNED <u>10/9/57</u>			
PHYSICIAN'S NAME (Type) <u>WALTER E. GUNBY JR.</u> <u>CAMBRIDGE MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kath S. Kilgus</u> ADDRESS <u>East New Market, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 10

NAME OF DECEASED *John A. Smith*
 SEX *M* AGE *45*
 DATE OF BIRTH *1912*
 PLACE OF BIRTH *St. Louis, Mo.*
 OCCUPATION *Engineer*
 CAUSE OF DEATH *Heart Disease*
 PLACE OF DEATH *Home*
 DATE OF DEATH *Oct 10 1957*
 TIME OF DEATH *10:30 AM*
 SIGNATURE OF PHYSICIAN *J. H. Jones*
 SIGNATURE OF REGISTRAR *W. B. Smith*

RECEIVED
 OCT 14 1957
 BUREAU V. 3